PASSPORT

Person-centered

Approaches

Supporting

Successful

Patient

Outcomes for

Recovery &

Transitions

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Name

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Your Rights During Transitions of Care:
A Guide for Health Care Consumers and Family Caregivers

Transitions of care (or care transitions) take place each time you go from one health care provider or health care setting to another. Problems often happen during these transitions because information is not communicated. You and your family have the right to care transitions that are safe and well coordinated. This guide can help you get the information and services you need and deserve each step of the way.

- ❒ You have the right to be treated fairly and with respect during care transitions.
- ❒ You have the right to care transitions that fit your situation and promote the health and well-being of you or your loved one.
- ❒ You have the right to know why a care transition is needed and to know your choices for care and services.
- ❒ You have the right to say what you want and need during care transitions.
- ❒ You have the right to take part in planning care transitions for yourself or your loved one.
- ❒ You have the right to know the possible benefits, risks, and costs of care transitions.
- ❒ You have the right to know and communicate with the people and organizations involved in your care transitions.
- ❒ You have the right to know the next steps during care transitions and whom to call if you have questions or problems.
- ❒ You have the right to privacy and to your health care information during care transitions.
- ❒ You have the right to get help when care transitions don't go well.

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Introduction

Admission to the hospital can be one of the most frightening experiences a person encounters. Hospitalization is usually an unplanned occurrence following an accident, injury or worsening of a chronic condition. Hospital admission or time spent during a hospitalization can be very stressful, but there are things you and your family can do to feel more confident, ease your stress, be a more effective advocate, and be a respected member of the healthcare team when you are hospitalized.

Be Prepared to Provide Information: You can be proactive, feel more confident in your dealings with hospital personnel, and make your transition into the hospital setting easier by providing your medical history immediately upon admission. This history, in writing should include:

- ❒ **A list of your allergies;**
- ❒ **A list of current medications and dosages;**
- ❒ **A list of <u>all</u> physicians and consultants who are caring for you, along with phone numbers;**
- ❒ **A clear and detailed written description of your current physical and mental capabilities and changes in your condition that may not be immediately evident will be helpful.**

As strange as it sounds, it is very important to think about discharge planning when you or your loved one first enters the hospital.

Find out the name of the attending physician of record for you or your loved one. This individual is the primary doctor on the case; he/she will communicate with the consulting physicians and coordinate the treatment plan. **Do not hesitate to continue to ask questions until you feel comfortable that you understand what is happening.** Ask for the phone number to reach the physician, what times are best to call and when the physician makes rounds. Make sure the "face" sheet on the hospital chart contains the name of the surrogate decision maker (a person who is authorized to speak on behalf of the patient when he/she is unable to speak) and the correct phone numbers.

Get to know the nurses who are caring for you or your loved one. They can answer your day-to-day questions and are an excellent source of information and support. The changing of shifts is a very busy time for the nurses, so try to hold your questions until the nurse coming on duty has received his/her report. Always be courteous in your communication with all hospital staff.

Speak to a hospital social worker or case manager. This individual will help you with discharge planning issues including arranging for home health care, determining what home health equipment you or your caregiver might need, and how to pay for additional expenses. It is important for the discharge planner to understand your physical and mental capabilities and challenges, so the most appropriate help can be ordered as part of your discharge plan. A good place to begin is to ask what the admitting diagnosis is and how long people admitted with this diagnosis typically stay in the hospital.

Organizing Your Care Transitions PASSPORT

The single most important thing you can do to assure a successful care transition is to create and maintain comprehensive information about your/your loved one's medical history. Keep this information in any form that works for you.

- ❒ Select a place to store the file that makes sense to you and where you can grab it quickly in an emergency or on the way to an appointment. Once you decide where to keep the file, keep it there. After you use it, always put it back in the same place.
- ❒ Keep the information up to date. Put a date on each page so you will know which information is the most current.
- ❒ Carry your **Care Transitions PASSPORT FILE** with you to all health related appointments. Use the space provided to make note of questions you want to ask at upcoming appointments.

PASSPORT File

- ❒ Personal Health Record (template included)
- ❒ Medication List (template included)

Insurance policy numbers, names, and telephone numbers of insurance claims representatives:

❒ Medicare Card* (may contain Social Security number TAKE EXTRA PRECAUTION)	❒ Long Term Care Insurance Policy
❒ Medicaid Card	❒ Vision Care
❒ Prescription Drug Insurance	❒ Dental Insurance
	❒ Other Medical Insurance Policies

Legal Information & Documents:

❒ The names and phone numbers of physicians with whom you have consultations particularly if you are taking medication prescribed by them. Tip: Most providers give you a business card, take a blank sheet of paper, and tape all the cards to the page.	❒ Power of Attorney
❒ Advanced Directives	❒ Guardianship Letters of Appointment
	❒ Name/phone number of funeral home
	❒ Name /phone number of your attorney
	❒ List of relatives and close friends to be contacted in an extreme emergency
	❒ Name /phone number of spiritual advisor

Community Supports:

❒ Regular pharmacy name and phone number
❒ Back-up pharmacy name and phone number Tip: An important step to recovery is getting your prescriptions filled in a timely manner. Some pharmacies offer a free delivery service, which may be helpful when you are leaving the hospital, even if you want to switch to another pharmacy later.
❒ Home Health Agency and Phone Number
❒ Durable Medical Equipment Provider

The Emergency Department

People living with chronic disease or a significant illness will likely experience a medical emergency at some point. No matter how careful you are, there will be a time when additional help or support is need from a medical provider in an emergent situation. When this happens you may seek help in the Emergency Department (ED) of a hospital. Being prepared will help you cope and receive the care you need more efficiently.

Preparing for an Emergency

❒ Have your **Care Transitions PASSPORT** with you because it contains the information care providers need.

❒ Get an "ER Buddy." Ask a trusted friend or family member to be your "ER Buddy." This should be someone who has a flexible enough schedule that they can respond to your request for support in an emergency.

❒ Pack a "Go Bag." If you have been to an emergency room more than a couple of times recently, pack a small "Go Bag" with a few toiletries and comfort items. Put the bag near the **Care Transitions PASSPORT** workbook where you can access it easily.

Navigating the Emergency Department

❒ *Relay Critical Information*

Share information as requested by the staff to help them understand your situation. Keeping your Care Transitions PASSPORT file up to date will keep you from having to rely on your memory. Tip: Update your Care Transitions PASSPORT after each medical appointment to keep it updated.

❒ *Wait Patiently*

Once you have shared the preliminary information requested, allow the medical staff to conduct their triage and initial assessment. Your caregiver may or may not be permitted to remain in the treatment area with you. Be patient and respect the privacy of those around you. If it is not possible for your caregiver to remain in the treatment area, he/she should ask how and at what frequency updates will be given.

❒ *Listen and Clarify*

Listen carefully to the health care professional. Take notes and ask questions until you clearly understand what they are saying. As you work with the ED staff, be clear about what you need.

Hospital Admission to Discharge

During your stay at the hospital, the care team will work to provide assessment, diagnosis, and initial treatment of your acute medical issues. However, it is important to understand that recovery and recuperation will take longer. As a part of the discharge planning process, issues related to the patient's care will need to be determined. As soon as a decision is made to admit you to the hospital, find out who will coordinate post-hospital services. Topics for discussion:

- ❒ Where will I go after the discharge?
- ❒ What functional capacity is critical for my discharge to home? (walk, climb steps, toilet, etc.)
- ❒ Who will provide services and supports for my recuperation or convalescence?
- ❒ What kinds of medical equipment will I need? (wheel chair, walker, hospital bed)
- ❒ What community services and supports might be needed/available to support my recovery? (mobile meals, in-home aides, transportation)
- ❒ What support might be needed/available for my caregivers?

Discharge planning is the process of making arrangements necessary for patients to leave the hospital safely with coordination and referral to the next level of support, services, convalesce, and/or treatment. Effective discharge planning requires a **team effort**. There are three critical goals in a good discharge plan to:

- ❒ Ensure the patient is being discharged to the right setting
- ❒ Ensure that the appropriate services and supports will be available
- ❒ Understand what is expected of the patient and those supporting him/her in the days following the discharge

You are not fully prepared for discharge until you have completed the Discharge Checklist.

Discharge Checklist

- ❒ **I have been involved in decisions about what will take place after I leave the hospital.**
- ❒ **I understand who I need to call for follow-up appointments.**
- ❒ **I know who to call if I forget something, have additional questions, or have a problem.**
- ❒ **I understand what I can expect in my recovery/recuperation over the next week.**
- ❒ **I understand what symptoms may signal a problem and the need for medical attention and what I should do if that happens.**
- ❒ **I understand what my medications are, why I am taking them, and how my medications have changed since my hospital admission and I understand how to take them.**
- ❒ **I understand the potential side effects of my medications and what to do and who to call if I have questions, or a problem.**
- ❒ **I have a list of agencies that have received a referral to provide care to me after I leave the hospital and their contact information.**
- ❒ **I understand what activities are allowed and what is prohibited during my recuperation.**

Important Care Transitions Resources

Options Counseling is a service offered by CRCs to help you plan for your future and/or current long-term services and supports needs. A certified options counselor will meet with you and through conversations learn about your preferences, service needs, and goals. The counselor will also provide support as you weigh the pros and cons of each of the various options and make well-informed decisions. With guidance from the counselor, you will develop an action plan to outline the steps you need to take to achieve your goals. Later, the counselor will check back with you to see if the plan is working for you. **For local information about this program, call _____.**

Community Care of North Carolina and Carolina ACCESS

These programs are two parts of the NC Division of Medical Assistance's managed care plan known as CCNC/CA. Being a member has the following advantages:

- ❒ You can choose your medical home that can help you be as healthy as possible through regular and preventive care. This includes regular checkups, flu prevention, and other services to keep you healthy.
- ❒ Treatment and/or medical advice is available 24 hours a day, 7 days a week.
- ❒ CCNC has health care managers who can assist you with understanding your doctor's instructions, making appointments, explaining how to take your medications and how to manage your chronic care needs.

For local information about this program, call _____.

Living Healthy (LH): The Living Healthy (LH) Program is a joint initiative of the NC Divisions of Aging and Adult Services and Public Health. LH is a highly participatory workshop that takes place once a week for six weeks. Two trained leaders (many of whom are volunteers living with chronic conditions themselves) facilitate each 2 ½-hour sessions that follow a detailed manual, so that each workshop is highly consistent. LH is designed to enhance regular treatment, and is appropriate for people with a wide variety of chronic health conditions and others who have been diagnosed with multiple chronic conditions. Each week, participants set small, achievable weekly goals & report to the group on the outcome. If a participant faces challenges, the entire group is there to provide support and help problem solve.

For local information about this program, call _____.

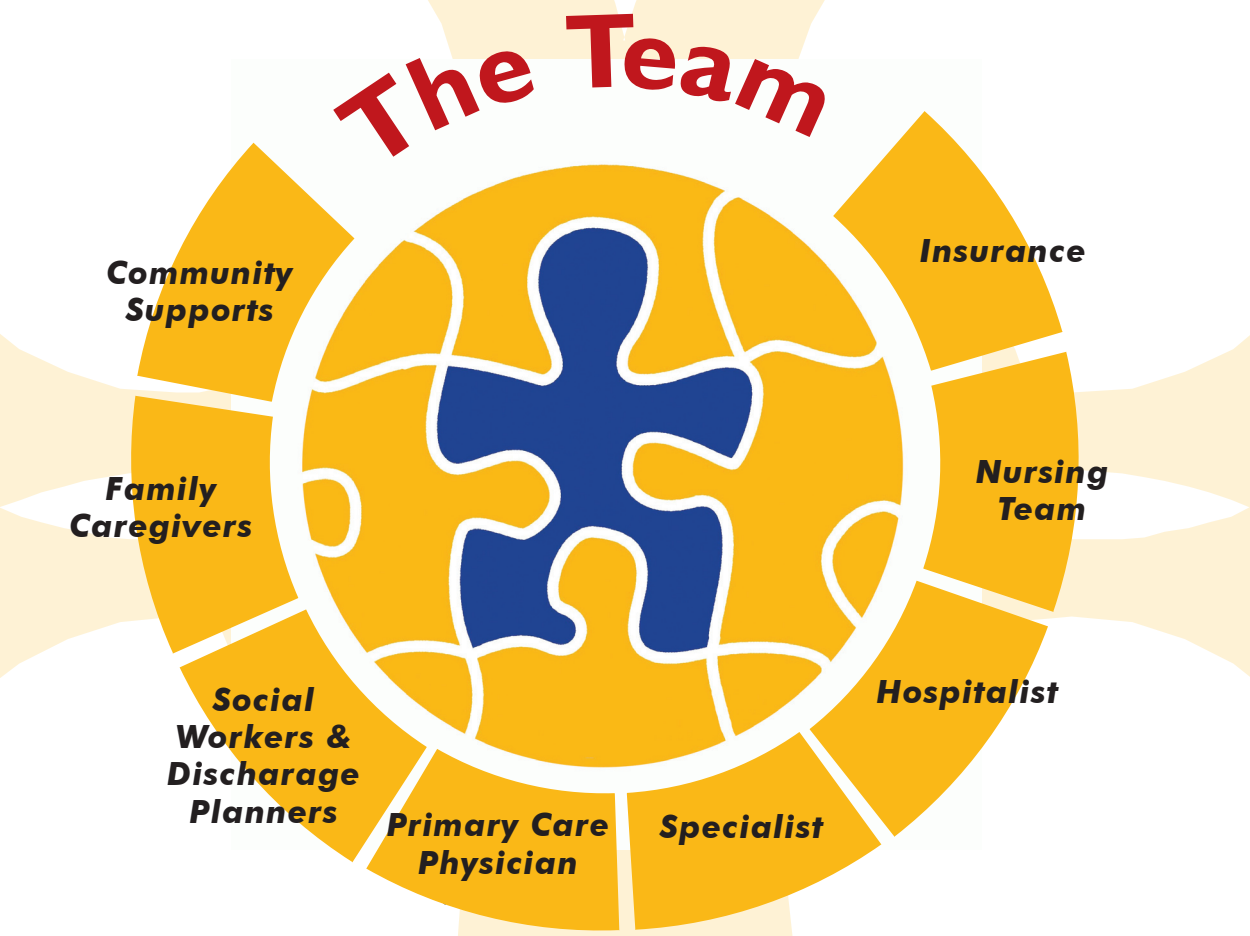
Money Follows the Person (MFP): is a NC Division of Medical Assistance demonstration project that assists people who receive Medicaid and live in inpatient facilities to move into their own communities with supports. The Project's intent is to support North Carolinians to have greater choice about where they receive their long-term supports. The Project also helps identify and address barriers to receiving quality, community-based, long-term care, and supports.

- ❒ Ongoing Community-Based Funding for Supports: MFP participants receive personal supports and other services through Medicaid's Community Alternatives Program ("CAP") or the PACE Program.
- ❒ Transition "Start Up" Funding: Each participant may be eligible for up to $3,000 in order to secure items and services needed to transition. These include security deposits, utility start up expenses, furniture, accessibility modifications, or other one-time services that may be required to transition.

For local information about this program, call _____.

North Carolina Senior Health Insurance Information Program (SHIIP): counsels Medicare beneficiaries and caregivers about Medicare, Medicare supplements, Medicare Advantage, Medicare Part D, and long-term care insurance. The counselors on the toll-free line offer free and unbiased information regarding Medicare health care products. SHIIP also helps people recognize and prevent Medicare billing errors and possible fraud and abuse through the NC Senior Medicare Patrol Program. **For local information about this program, call 800-443-9354.**

Successful Care Transitions Require Teamwork!



Tips for working with Health Care Professionals

- ❒ Write questions down so you will not forget them.
- ❒ Be clear about what you want to say, try not to ramble.
- ❒ If you have lots of things to talk about make a consultation appointment, so the physician can allow enough time to meet with you in an unhurried way.
- ❒ Learn about your medical condition or disability; ask your nurse or physician to identify resources for good information.
- ❒ Learn the staff routine in the hospital or physician's office so you can help the system work better for you.
- ❒ Recognize that not all questions have answers- especially those beginning with "why."
- ❒ Work to maintain objectivity about the situation and try to separate your feelings and fears as much as possible. Always remember that you and your care provider are members of the same team.
- ❒ Identify people you need to help support you when you are discharged from the hospital. No one should try to go though a care transition alone.

daas NORTH CAROLINA Division of Aging and Adult Services
dhhs nc department of health and human services